We will consider for publication only letters submitted in duplicate, printed in letter-quality type without proportional spacing and not exceeding 450 words. All the authors must sign a covering letter transferring copyright. Letters must not duplicate material being submitted elsewhere or already published. We routinely correspond only with authors of accepted letters. Rejected letters are destroyed. Accepted letters are subject to editing and abridgement.

Seules peuvent être retenues pour publications les lettres reçues en double dont la longueur n'excède pas 450 mots. Elles doivent être mécanographiées en qualité "correspondance" sans espacement proportionnel. Tous les auteurs doivent signer une lettre d'accompagnement portant cession du copyright. Les lettres ne doivent rien contenir qui ait été présenté ailleurs pour publication ou déjà paru. En principe, la rédaction correspond uniquement avec les auteurs des lettres retenues pour publication. Les lettres refusées sont détruites. Les lettres retenues peuvent être abrégées ou faire l'objet de modifications d'ordre rédactionnel.

Eugenic abortion: an ethical critique

I was startled to read Dr. Malcolm N. Beck's article (*Can Med Assoc J* 1990; 143: 181–186), not because of Beck's opposition to abortion but because of the illogical twists and turns and wordplay in his discussion.

The facts Beck presents are frequently flawed and perverted to secure the impression he seeks to convey. For example, the effects of rubella during pregnancy were not "newly demonstrated" in 1967 but had been known for a quarter of a century.[1]

Beck's assertion that "physicians are not only accepting and sometimes promoting [prenatal diagnostic techniques] but also are being increasingly pressed by older mothers and their partners to do them" is generally true. Unfortunately, it is also true that some physicians avoid mentioning the increased risk of fetal chromosomal anomalies or the availability of amniocentesis to pregnant women over the age of 35 and thus render themselves open to a likely successful malpractice suit.

Beck's distinction between abortion on the grounds of genetic abnormality and abortion carried out because the pregnancy is unwelcome appears to imply acceptance of the latter and puts him in a curious position.

Beck prefers the term "reduction of multiple pregnancies" that result from assisted ovulation or fertilization rather than "selective feticide" and, astonishingly, considers this procedure "a goal compatible with the traditional scope of medicine". His view is clearly not shared by the editorial writer in the *Lancet*[2] who stated that "there are compelling ethical and medical arguments to ensure that fetal reduction does not become the management method for ovulation induction, [in-vitro fertilization] and related techniques."

Beck attempts to discredit amniocentesis by quoting rare single case reports of damage presumed to be due to needle puncture, none of which were reported in the past 8 years and most of which occurred before the general use of real-time ultrasound monitoring. He equates the number of potential births of babies who have a severe genetic disorder with the number of miscarriages during the few weeks after amniocentesis or chorionic villus sampling, carefully ignoring the fact that the miscarriages may have been totally unrelated to the amniocentesis and that the normality of these embryos and fetuses is a matter of speculation.

The identification and abortion of the genetically abnormal conceptus is not a procedure invented by physicians or geneticists. It is a natural process, of remarkable efficiency, with a major role in reproduction. A large proportion of conceptuses (at least one-third and possibly as many as two-thirds) are developmentally flawed and spontaneously aborted.

Beck maintains that physicians should not be involved in prenatal screening for genetic anomalies or in the termination of a pregnancy involving a fetus with an abnormality of this type. This would mean, for example, that parents who have cared for a child with Tay–Sachs disease and watched the relentless physical and mental deterioration must, in the event of another pregnancy, take their chances of a repeat experience, with no hope of therapeutic diagnostic intervention. Concomitantly, Beck apparently approves of the killing of normal fetuses in iatrogenically engineered multiple pregnancy. Many of us would have difficulty reconciling these views.

Prenatal genetic monitoring is here to stay. Beck would do well to devote his interest and energies to ensuring that such monitoring is carried out responsibly. There is no question that decisions on prenatal monitoring and the continuation of pregnancy are often enormously difficult and always emo-

tionally charged. With inevitable advances in the ability to determine genetic constitution these decisions will become more difficult, not less so. It is important to remember that in this area there are no right and wrong decisions, simply those deemed best by the individuals most closely involved.

J. Philip Welch, MB, ChB, PhD, FCCMG
Professor of pediatrics
Co-director
Maritime Genetic Antenatal Clinic
Dalhousie University
Halifax, NS

References

1. Gregg NM: Congenital cataract following German measles in the mother. *Trans Ophthalmol Soc Aust* 1942; 3: 35–46
2. Selective fetal reduction [E]. *Lancet* 1988; 2: 773–775

Dr. Beck's article presents a very biased argument against the role of prenatal genetic diagnostic services in the delivery of health care to pregnant women in this country.

I am uncertain if the author has any direct involvement in the delivery of such services. However, it is well appreciated by those of us who do that advances in reproductive technologies, including first-trimester chorionic villus sampling and second-trimester genetic amniocentesis, have provided a wide range of informed options for pregnant women and couples at risk of having children with genetic abnormalities.

By focusing on the difficult issue of abortion of fetuses with genetic disorders the author has presented a slanted view of the very broad field of prenatal diagnosis. Moreover, the article is full of inaccuracies; for example, "There is no baby, no name, no photograph, no funeral, no grave."[1] In our centre we offer intensive grief counselling, supportive services, photos, personal contact with the baby, memorial services and long-term follow-up to the woman and her partner after termination of pregnancy.

Abortions are done not because of the abnormalities detected but because of parental distress and the anguished response to having a handicapped child. The term "eugenic abortion" is erroneous — prenatal diagnosis programs are not motivated by eugenics, and the implications of such a term are despicable. I am disappointed that *CMAJ* chose to publish this personal essay without either an accompanying editorial or a scientific article articulating the many facets and potential benefits of prenatal testing.

Cheryl R. Greenberg, MD, CM, FRCPC, FCCMG
Clinical geneticist
Department of Pediatrics
Children's Hospital
Winnipeg, Man.

In his comprehensive, thoughtful article Dr. Beck asks us to raise the level of our debate about eugenic abortion.

I write as a psychiatrist with 25 years' experience in the field of mental retardation and a special interest in Down's syndrome. Because prenatal diagnosis of Down's syndrome is possible one cannot avoid the ethical dilemma in which the "selective feticide" option is widely available at a time when "the future for people with Down Syndrome looks brighter than ever".[1]

As my personal views about eugenic abortion become more and more in line with Beck's my inclination is to advise a mother carrying a fetus with Down's syndrome that the preferred options are to raise the child or have him or her adopted immediately after birth. However, should she decide to terminate the pregnancy I will provide the psychologic support that any person facing such a difficult decision deserves, and in so doing I will feel that I have neither replicated the profession's evil in Germany during the 1930s nor seriously compromised its image of respect in the 1990s.

Bruce D. McCreary, MD, FRCPC
Associate professor
Department of Psychiatry
Queen's University
Kingston, Ont.

Reference

1. Selikowitz M: *Down Syndrome: the Facts*, Oxford Med Publ, New York, 1990: 198

To state that the active search for antenatal evidence of grave fetal disability is an issue to be carefully distinguished from the prochoice attitude toward abortion is incomprehensible: such a search is only justified if the pregnancy occurs in one who is willing to choose an abortion rather than risking giving birth to a defective child.

We live in a world with frightening population growth and progressively limited resources; at the same time we are rightly concerned with what it means to be human. The concept of people pollution, which encapsulates these two issues, has become increasingly significant and has been the highlight of a series of Banff conferences organized by faculty members of the University of Calgary and members of the Engineering Institute of Canada. At the third conference on "Man and His Environment" Dr. Thomas Settle[1] set the tone with a definition of being human: "the ability to solve problems, to play and worship, to apprehend and keep affection and respect for company, to have purpose, and to possess integrity [and] to accept obligations imposed within a group." Clearly this is a state that must be nurtured by healthy pregnancy and the dedicated care of children.

The human infant is born prematurely compared with its mammalian cousins, which are sufficiently well developed to follow the herd almost from the